2022
coding & reimbursement guide

BREAST HEALTH SOLUTIONS

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Breast Surgery

Physician Professional Payment

CPT®[1] Code/ HCPCS[2] Code	Description	Place-of-Service	RVU[3]	2022 National Average Medicare Rate[4]
19301	Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy);	Professional (Facility)	19.74	$683.13
19302	Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy); with axillary lymphadenectomy	Professional (Facility)	27.11	$938.17
19316	Mastopexy	Professional (Facility)	23.43	$810.82
19318	Reduction mammaplasty	Professional (Facility)	32.33	$1,118.82
38500	Biopsy or excision of lymph node(s); open, superficial	Professional (Facility)	7.61	$263.35
38525	Biopsy or excision of lymph node(s); open, deep axillary node(s)	Professional (Facility)	13.15	$455.07
38900	Intraoperative identification (eg, mapping) of sentinel lymph node(s) includes injection of non-radioactive dye, when performed (List separately in addition to code for primary procedure)	Professional (Facility)	4.08	$141.19
76098	Radiological examination, surgical specimen	Professional (Facility)	0.45	$15.57
19499	Unlisted Procedure, breast	Professional (Facility)	N/A	Determined by contractors

Facility Payment

CPT®[1] Code / HCPCS[2] Code	Description	Place-of-Service	APC[5]	Status Indicator[5]	2022 National Average Medicare Rate[5]
19301	Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy);	Hospital	5091	J1	$3,225.00
		ASC	NA	A2	$1,205.70
19302	Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy); with axillary lymphadenectomy	Hospital	5092	J1	$5,652.10
		ASC	NA	A2	$2,308.67
19316	Mastopexy	Hospital	5092	J1	$5,652.10
		ASC	NA	A2	$2,308.67
19318	Reduction mammaplasty	Hospital	5092	J1	$5,652.10
		ASC	NA	A2	$2,308.67
38500	Biopsy or excision of lymph node(s); open, superficial	Hospital	5091	J1	$3,225.00
		ASC	NA	A2	$1,205.70
38525	Biopsy or excision of lymph node(s); open, deep axillary node(s)	Hospital	5091	J1	$3,225.00
		ASC	NA	A2	$1,205.70
38900	Intraoperative identification (eg, mapping) of sentinel lymph node(s) includes injection of non-radioactive dye, when performed (List separately in addition to code for primary procedure)	Hospital	NA	N	Packaged
		ASC	NA	N1	Packaged
76098	Radiological examination, surgical specimen	Hospital	5524	Q2	$493.48
		ASC	NA	N1	Packaged
19499	Unlisted procedure, Breast	Hospital	5091	J1	$3,225.00
		ASC	NA	NA	NA
C9728	Placement of interstitial device(s) for radiation therapy/surgery guidance (e.g., fiducial markers, dosimeter), for other than the following sites (any approach): abdomen,pelvis, prostate, retroperitoneum, thorax, single or multiple	Hospital	5613	S	$1,289.67
		ASC	NA	J8	$870.84
A4648	Tissue marker, implantable, any type, each	Hospital	NA	N	NA
		ASC	NA	NA	NA

Breast Surgery

Modifier Information[1]

Modifier	Description	Explanation
26	Professional component	Certain procedures are a combination of a physician or other qualified health care professional component and a technical component. When the physician or other qualified health care professional component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number
59	Distinct Procedural Service	Under certain circumstances, it may be necessary to indicate that procedure or service was distinct or independent from other non-E/M services performed on the same day
76	Repeat procedure or service by same physician or other qualified health care professional	It may be necessary to indicate that a procedure or service was repeated by the same physician or other qualified health care professional subsequent to the original procedure or service. The circumstance may be reported by adding modifier 76 to the repeated procedure or service. Note: this modifier should not be appended to an E/M service
77	Repeat Procedure by Another Physician or Other Qualified Health Care Professional	It may be necessary to indicate that a basic procedure or service was repeated by another physician or other qualified health care professional subsequent to the original procedure or service
XE*	Separate Encounter	A service that is distinct because it occurred during a separate encounter
XP*	Separate Practitioner	A service that is distinct because it was performed by a different practitioner

* Specific Modifiers for Distinct Procedural Services, CMS Transmittal 1422, available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1422OTN.pdf

Status Indicator Information[5]

Status Indicator	OPPS Status Indicator
T	Paid separately under OPPS but multiple procedure reduction applies
N	Payment is packaged into payment for other services. Therefore, there is no separate APC payment
J1	Comprehensive APC paid under OPPS; all covered Part B services on the claim are packaged with the primary “J1” service for the claim, except services with status indicator “F”, “G”, “H”, “L” and “U”
Q1	Payment is packaged if billed on the same claim as a HCPCS code assigned status indicator “S”, “T”, or “V”; otherwise payment is made through a separate APC payment
Q2	Q2 is packaged if on the same “claim” rather than date of service.
S	Significant procedure paid as separate APC payment under OPPS. Multiple procedure reduction does not apply
U	Brachytherapy sources paid as separate APC payment under OPPS
Payment Indicator	**ASC Payment Indicator**
A2	Surgical procedure on ASC list in CY 2007; payment based on OPPS relative payment weight
J8	Device-intensive procedure; paid at adjusted rate
N1	Packaged service/item; no separate payment made

1. American Medical Association (AMA), 2022 Current Procedural Terminology (CPT), Professional Edition. CPT codes and descriptions only are copyright 2021 AMA. All rights reserved. The AMA assumes no liability for data contained herein. No fee schedules, basic units, relative or related listings are included in CPT. Applicable FARS/DFARS Restrictions Apply for Government Use.
2. Centers for Medicare & Medicaid Services (CMS), 2022 Healthcare Common Procedure Coding System (HCPCS) codes, available at http://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html
3. The 2022 physician relative value units (RVUs) are from the 2022 Physician Fee Schedule (PFS) Relative Value Files, file RVU22A, available from the CMS website at https://www.cms.gov/Medicare/Medicare-Feefor-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files
4. The national average 2022 Medicare rates to physicians shown are based on the 2022 conversion factor of $34.6062 and do not reflect payment cuts due to sequestration. Medicare payment for a given procedure in a given locality in 2022 should be available in the Medicare Physician Fee Schedule Look-up file accessible through the CMS website at https://www.cms.gov/apps/physician-fee-schedule/overview.aspx. Any payment rates listed may be subject to change without notice. Actual payment to a physician will vary based on geographic location and may also differ based on policies and fee schedules outlined as terms in your health plan and/or payer contracts.
5. The national average 2022 Medicare rates and status indicators for the hospital outpatient setting are from the 2022 Hospital Outpatient Prospective Payment System (OPPS) Correction release, Addenda B, and D1 accessible at https://www.cms.gov/license/ama?file=/files/zip/2022-nfrm-opps-addenda.zip [cms.gov]. The national average 2022 Medicare rates and status indicators for the ambulatory surgical center setting are from the 2022 Ambulatory Surgical Center (ASC) Payment Correction release, Addenda AA, BB, and DD1, accessible at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates. Any payment rates listed are Medicare national averages that may be subject to change without notice and do not reflect payment cuts due to sequestration. Actual payment to a hospital or ambulatory surgical center will vary based on geographic location and may also differ based on policies and fee schedules outlined as terms in your health plan and/or payer contracts.

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